



Memorandum

Date . NOV 5 1993

From Bryan B. Mitchell *Bryan Mitchell*
Principal Deputy Inspector General

Subject Audit of California Department of Health Services Recovery of Medicaid Third
Party Liability Payments for the Period July 1, 1988 Through June 30, 1992

To (A-09-92-00095)

Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on November 9, 1993 of our final report. A copy is attached.

The objective of our audit was to determine if the California Department of Health Services (DHS) gave the Federal Government full financial credit for casualty third party liability (TPL) settlements and awards for the period July 1, 1988 through June 30, 1992.

Our review disclosed that DHS did not comply with Federal laws on TPL credits. Instead of recovering amounts due, DHS allowed recipients to keep funds that rightfully belonged to Medicaid.

Using statistical sampling methods, we estimated that DHS allowed recipients to retain at least \$7,592,786 in Federal monies prior to the Medicaid program being fully reimbursed for costs it incurred on behalf of the recipients.

The DHS allowed recipients to keep settlement and award amounts that should have been recovered for Medicaid because of two State laws. One State law provided that DHS must give the recipients at least one-half the settlements after subtracting for attorney's fees, litigation costs, and medical expenses related to their injuries and paid by the recipients. The other law indicated that DHS may provide recipients with amounts in excess of one-half the settlements in cases of undue hardship.

We recommend that DHS: (1) refund \$7,592,786 to the Federal Government; and (2) establish procedures to ensure that the Federal Government is given full credit for TPL settlements and awards in accordance with Federal laws, regardless of its own State laws.

Page 2 - Bruce C. Vladeck

The DHS did not concur with our finding and recommendations. It believed that the Office of Inspector General misinterpreted the applicable Federal laws. Additionally, DHS concluded that if it were to follow our interpretation, it would substantially reduce the State's recovery of TPL monies. After consideration of DHS's comments and consultation with the Office of General Counsel, we continue to believe that our finding and recommendations are valid.

For further information, contact:

Herbert Witt
Regional Inspector General
for Audit Services, Region IX
(415) 556-5766

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CALIFORNIA DEPARTMENT OF HEALTH
SERVICES RECOVERY OF MEDICAID
THIRD PARTY LIABILITY PAYMENTS**

**FOR THE PERIOD
JULY 1, 1988 THROUGH JUNE 30, 1992**



NOVEMBER 1993 A-09-92-00095



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza
San Francisco, CA 94102

CIN: A-09-92-00095

Ron Joseph
Interim Director
Department of Health Services
714 P Street
Sacramento, California 95814

Dear Mr. Joseph:

This final report provides you with the results of our audit of the California Department of Health Services (DHS) recovery of Medicaid third party liability (TPL) payments. Our audit objective was to determine if DHS gave the Federal Government full financial credit for casualty TPL settlements and awards for the period July 1, 1988 through June 30, 1992. Federal law required that the Medicaid program was to be fully reimbursed before recipients received any money from TPL settlements or awards.

Our review disclosed that DHS did not comply with the Federal requirements on TPL credits. The DHS did not give Medicaid full financial credit for settlements and awards. Instead of recovering amounts due, DHS allowed recipients to keep funds that rightfully belonged to Medicaid.

Using statistical sampling methods, we estimated that DHS allowed recipients to retain at least \$7,592,786 in Federal monies prior to the Medicaid program being fully reimbursed for costs it incurred on behalf of the recipients.

The DHS allowed recipients to keep settlement and award amounts that should have been recovered for Medicaid because of two State laws. One State law provided that DHS must give recipients at least one-half the settlements after subtracting for attorney's fees, litigation costs, and medical expenses related to their injuries and paid by the recipients (this provision was meant to encourage recipients to seek TPL reimbursements and thereby increase the program's overall recoveries). The other law indicated that DHS may provide recipients with amounts in excess of one-half the settlements in cases of undue hardship (severe physical injuries accompanied by a need for additional funds). The State laws, however, conflicted with Federal requirements, and the State had been so advised by the Health Care Financing Administration (HCFA) in June 1988.

We recommend that DHS: (1) refund \$7,592,786 to the Federal Government, and (2) establish procedures to ensure that the Federal Government is given full credit for TPL settlements and awards in accordance with Federal laws and regulations, regardless of its own State laws.

The DHS did not concur with our findings and recommendations (see the Appendix for DHS's comments in its entirety). It did not agree with our interpretation of the various applicable criteria and maintained that if it followed our interpretation it would result in a reduction in recoveries. After consideration of DHS's comments, we believe that our conclusions and recommendations are still valid.

INTRODUCTION

BACKGROUND

Medicaid, authorized under Title XIX of the Social Security Act (the Act), was established to pay for the cost of necessary medical services for eligible persons whose income and resources were insufficient to pay for their health care. The DHS is the single State agency responsible for administering the Medicaid program in California.

A third party is any individual, entity, or program that is, or may be, liable to pay all or part of the cost of any medical assistance furnished to a Medicaid applicant or recipient. Casualty recoveries are usually obtained from automobile insurance, court judgments or settlements from a liability insurer, and other liable persons or entities.

States must take reasonable measures to determine the legal liability of third parties to pay for services that Medicaid would otherwise incur. In addition, if Medicaid has already paid for care that a third party is liable for, the agency must seek repayment from the third party. Any recoveries act as reductions to expenditures and, thus, reduce a State's claim on Federal Medicaid funds.

Federal law required that Medicaid recipients assign their rights to medical support and third party payments as a condition of eligibility. Section 1902 of the Act specified that State plans for medical assistance must:

"...(a)(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1912."

Section 1912(b) of the Act required that the Medicaid program be fully reimbursed before the recipient received any money from the settlement or award:

"Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual."

In addition, the Act required that the State seek reimbursement when the amount it expects to receive exceeds the cost of recovery:

"...that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability."
(Section 1902(a)(25)(B))

In determining the appropriate Medicaid reimbursement, States can take into consideration any legal costs of obtaining settlements. Specifically, HCFA's State Medicaid Manual section 3907 stated that:

"Legitimate costs of obtaining the settlement or award, such as attorney fees, may be deducted prior to reimbursement to the Medicaid program."

In order to provide for its share of legal costs, DHS reduced its liens¹ by: (1) 25 percent to provide for its share of the attorney's fees, and (2) the ratio of the full amount of the Medicaid expenditures to the full amount of the settlement multiplied by the litigation expenses to provide for its share of the legal costs.

The DHS retained information on its closed casualty cases in both a case file and a computer file. A closed case was one in which

¹ A lien was the legal device DHS used to notify the liable third party of its claim for reimbursement. The amount of the lien was the total Medicaid expenditures relating to the casualty.

the final settlement had been received and no further action was pending. The case file contained all the information and documentation related to the case while the computer file contained only selected information. The information on the computer file included, but was not limited to, the recipient's name, Medicaid number, and transaction codes².

Although Federal rules provided that the Federal share must be fully recovered before recipients could receive monies, State laws differed. Specifically, California's Welfare and Institutions Code (WIC) section 14124.78 (50 percent rule) stated that:

"...in no event shall the director's claim exceed one-half of the beneficiary's recovery after deducting for attorney's fees, litigation costs, and medical expenses relating to the injury paid for by the beneficiary."

In addition, WIC section 14124.71(b)(2) (compromise rule) allowed DHS to:

"Waive any such claim, in whole or in part, for the convenience of the director, or if the director determines that collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased."

When monies were provided to recipients in accordance with the above two State laws, the recovery unit staff coded the computer file with transaction codes 449 and 440, respectively.

SCOPE

Our examination was made in accordance with generally accepted government auditing standards. The objective of our audit was to determine if DHS gave the Federal Government full financial credit for casualty TPL settlements and awards for the period July 1, 1988 through June 30, 1992. The DHS's casualty liens totaled about \$232 million, and its collections totaled about \$85 million during this period.

² A transaction code was a numeric designation which identified monetary events in the case. These events included such items as the amount of the Medicaid lien, the amount the lien was reduced for Medicaid's share of the attorney's fee, the amount the lien was reduced in order to give the recipient one-half the settlement after deducting for attorney fees, litigation costs, and medical expenses relating to the injury which were paid by the recipient (code 449), and the amount the lien was reduced for hardship to the recipient (code 440).

In order to accomplish our objective, we reviewed a random statistical sample of 300 of the 2,445 closed cases which utilized transaction codes 440 or 449. The DHS collected \$3,655,012 on these 300 cases.

In each of the 300 cases, we calculated the amount of money DHS should have collected using Federal criteria and compared it to the amount it did collect. Specifically, we determined the gross amount of the Medicaid lien and then reduced it to provide for the State's share of attorney fees and litigation costs in accordance with its State laws. This reduced lien amount was called the net lien.

We then determined if the settlement was sufficient to compensate the attorney, pay the litigation costs, and reimburse DHS for the net lien amount. If it was, we questioned the Federal share of the difference between the net lien amount and the amount DHS collected. If the settlement amount was not sufficient, we questioned the Federal share of the difference between the amount of the settlement less actual legal fees and costs and the amount DHS collected. We projected the results of our statistical sample to the universe of 2,445 closed cases which utilized transaction codes 440 or 449.

We did not verify if the amounts stated in the case files, such as the amounts for attorney fees and settlements, were accurate. Specifically, we did not obtain additional documentation from outside sources to substantiate the accuracy of the amounts stated. We also did not verify if amounts actually recorded as collections in the 300 cases were credited to the Federal Government. In a prior audit (A-09-91-00127, dated November 19, 1992), we examined the reporting of TPL credits to the Federal Government for the period July 1, 1988 through March 31, 1991.

The limited objectives of our audit did not require a complete assessment of DHS's internal control system. Our assessment was limited to a preliminary review of the controls to obtain an understanding of DHS's collection, recording, and reporting of casualty TPL recoveries.

The fieldwork was performed at DHS's offices in Sacramento, California during the period June 1992 through April 1993.

FINDINGS AND RECOMMENDATIONS

We found that DHS did not give the Federal Government full financial credit in 241 of the 300 casualty cases. Projecting the results of our sample to the universe of 2,445 closed cases, we estimated, at the 90 percent confidence level, that the Federal share of money given to recipients prior to Medicaid reimbursement was between \$7,592,786 and \$11,311,086, with the midpoint being \$9,451,936. We are 95 percent certain that the

Federal share of the amount available and not collected was at least \$7,592,786.

As previously noted in the background section of this report, States were required by section 1912(b) of the Act to retain any part of settlements necessary to reimburse it for medical expenditures made on behalf of recipients (with appropriate reimbursement to the Federal Government) before providing any monies to recipients. Additionally, section 1902(a)(25) required States to seek reimbursement from liable third parties to the limit of legal liability.

Our review of the random sample of 300 closed case files showed that DHS reduced its liens in 196 of the cases for the 50 percent rule, in 78 cases for the compromise rule, and in 9 cases for miscellaneous errors. A total of 200 cases had 1 error, 40 contained 2 of the above types of errors, and 1 case had all 3 types of errors. Thus, 241 of the 300 cases had errors³. The table below summarizes the results of our sample and its projections. (All dollar value amounts represent the Federal share.)

<u>Type of Error</u>	<u>Sample</u>		<u>Projection</u>	
	<u>No. of Errors</u>	<u>Dollar Value of Errors</u>	<u>No. of Errors</u>	<u>Dollar Value of Midpoint</u>
50 percent rule	196	\$767,727	1,597	\$6,256,971
Compromise rule	78	388,376	636	3,165,264
Miscellaneous	<u>9</u>	<u>3,644</u>	<u>73</u>	<u>29,701</u>
Totals	<u>283</u>	<u>\$1,159,747</u>	<u>2,306</u>	<u>\$9,451,936</u>

50 Percent Rule

In 196 of the 300 cases, DHS reduced its liens by a total of \$767,727 for the 50 percent rule. The 50 percent rule stated that DHS's recovery would not exceed one-half of the settlements after deducting for attorney fees, litigation costs, and medical expenses that were paid by recipients and related to their injuries. Projecting to the universe of 2,445 closed cases, we estimated that the reductions would total \$6,256,971 for this type of error.

³ For the 41 cases with multiple errors, we identified that portion of the total dollar value of error related to each type.

The following describes an actual case involving the 50 percent rule. In May 1985, a young woman gave birth to a stillborn child, received Medicaid benefits totaling \$106,983, and subsequently, in September 1989, obtained a \$150,000 medical malpractice settlement from an insurance carrier. The attorney's fee was \$48,506, and litigation costs were \$2,641. After reimbursing the attorney, there was \$98,853 remaining from the settlement funds (\$150,000 - \$48,506 - \$2,641). The DHS received one-half of the \$98,853, or \$49,426, and allowed the recipient to retain \$49,427.

Under Federal criteria, the Federal Government should have been given credit for its share (50 percent) of the full net lien (\$78,353⁴), or \$39,176 before the recipient received any monies. However, DHS credited the Federal Government with only \$24,713 (50 percent of the actual recovery of \$49,426). This action resulted in an error of \$14,463 (\$39,176 - \$24,713).

Federal law, specifically section 1912(b) of the Act, required that the Medicaid program, in particular the Federal Government's portion of its financing, be reimbursed before recipients received any monies from settlements. Any funds collected by the State or obtained by recipients should, after reimbursement to cover legal fees and costs, be used to reimburse the program for its medical payments. Any remaining funds could then be paid to recipients. This treatment is required even when recipients seek and obtain settlements on their own because as a condition of eligibility recipients have assigned their rights of recovery and, thus, have essentially collected the TPL payments on behalf of the State.

The State was notified by HCFA that its State laws were not in compliance with Federal laws. In a memorandum, dated June 1, 1988, Region IX of HCFA informed all States in its region that State laws which allowed recipients to keep fixed portions of settlements were not in compliance with Federal laws and regulations. In November 1991, HCFA notified California that its WIC section 14124.78 (50 percent rule) did not comply with section 1912(b) of the Act with respect to assuring full reimbursement of the Federal share of TPL settlements and awards.

⁴ The net lien of \$78,353 was arrived at by reducing the Medicaid expenses of \$106,983 to account for the State's share of legal fees and litigation costs. This reduction consisted of \$26,746 relating to a 25 percent reduction in the total lien to account for legal fees ($\$106,983 \times 25 \text{ percent} = \$26,746$) and \$1,884 relating to its pro rata share of costs ($\{\$106,983 \div \$150,000\} \times \$2,641 = \$1,884$). Thus, the net lien would be \$78,353 ($\$106,983 - \$26,746 - \$1,884$).

In January 1992, DHS requested that HCFA reconsider its decision. In its request, DHS claimed that it collected more casualty recoveries per Medicaid recipient than either New York, Texas, or Pennsylvania. It contended that the main reasons it collected more than the other States was the fact that attorneys were required to notify DHS of litigation involving a Medicaid recipient and its use of the 50 percent rule (which, according to the State, provided an incentive for recipients to seek recoveries). The DHS said that when the legislation that required attorney notification was considered it was strongly opposed by an attorney association and that the 50 percent rule was included in the legislation as a quid pro quo to overcome its opposition. In September 1992, HCFA notified DHS that its State law remained in opposition with current Federal statutes.

Compromise Rule

The DHS reduced its liens in 78 of the 300 cases by a total of \$388,376 for the compromise rule. This rule allowed DHS to reduce its liens, giving the amount of reduction to recipients, in cases of undue hardship. The hardship reductions in all 78 instances were made after the settlements or awards had been granted. We estimated that the Federal share of the reductions for this type of error would total \$3,165,264 if projected to the universe of 2,445 closed cases.

The DHS did not have written procedures or guidelines describing when a reduction should be granted or the amount of the reduction. Each recipient or attorney who requested a hardship reduction was required to fill out a questionnaire. This questionnaire provided DHS with information on the recipient's medical prognosis, his or her earnings potential, and the purpose for which any additional funds would be used. The DHS determined whether or not to reduce its lien for the compromise rule and the amount of the reduction on a case-by-case basis.

The following illustrates an actual case involving the compromise rule. A 21-year-old male was rendered a quadriplegic as a result of a shooting incident which occurred in June 1986. He received \$316,299 in Medicaid benefits and obtained a settlement in May 1992 from a liability insurer for \$4,020,000. The attorney's fee was \$1,608,000, and the litigation costs were \$2,689, leaving \$2,409,311 (\$4,020,000 - \$1,608,000 - \$2,689) available to satisfy the State's lien.

The DHS reduced its lien to provide for its share of the attorney's fee⁵ and litigation costs⁶, yielding a net lien of \$237,012 (\$316,299 - \$79,075 - \$212) for which the Federal Government should have been reimbursed its 50 percent share, or \$118,506. However, after the settlement had occurred, DHS agreed to accept \$149,656 as full payment because the recipient claimed an undue hardship. Thus, only 50 percent of the \$149,656 or \$74,828, was credited to the Federal Government. Therefore, the Federal portion of the Medicaid lien was underpaid by \$43,678 (\$118,506 - \$74,828). In this particular example, a copy of the hardship questionnaire was not in the case file nor was there any documentation as to why the compromise was made or how the amount was calculated.

This treatment of providing settlement monies to recipients before the Federal Government is reimbursed for its share of expenses is also contrary to Federal law, specifically section 1902(a)(25)(B) of the Act. This section required that the State seek reimbursement to the full extent of its legal liability. The only qualification of this mandate to pursue third party payments is when the cost of recovery would exceed the amount recoverable.

Although the State is free to give part (or even all) of its recovery to a recipient, Federal law does not allow a State to give away the Federal share. In fact, section 1902(a)(25) clearly required that the State act on behalf of the Federal Government in pursuing FFP attributed to the liability of third parties, as long as it is cost effective to do so. Any such gifts to recipients could be made only after the State had credited the Federal Government with its proper share, essentially returning those monies to the Federal Government. By giving the Federal share to recipients, DHS, in effect, permitted Federal Medicaid funds, intended for medical care, to be used for other purposes.

Miscellaneous Errors

The DHS effectively reduced its liens in 9 of the 300 cases by a total of \$3,644 because of miscellaneous errors. We estimated that the Federal share of such reductions would total \$29,701 if projected to the universe of 2,445 cases. These miscellaneous errors included such things as mathematical mistakes and the use of wrong amounts in its calculations.

⁵ A 25 percent reduction in the lien for the State's share of the attorney fee was \$79,075 ($\$316,299 \times 25$ percent).

⁶ The State's share of litigation costs was \$212 ($(\$316,299 \div \$4,020,000) \times \$2,689$).

Conclusion and Recommendations

Our review disclosed that DHS did not give the Federal Government full financial credit for TPL settlements and awards in accordance with Federal criteria. Instead, it permitted recipients to retain, prior to Medicaid's full recovery of FFP, amounts recovered from third party sources. We estimated that during the period July 1, 1988 through June 30, 1992 DHS allowed recipients to retain at least \$7,592,786 (Federal share) in available settlement monies prior to the Federal Government being fully reimbursed.

Therefore, we recommend that DHS:

1. Refund \$7,592,786 to the Federal Government.
2. Establish procedures to ensure that the Federal Government is given its full credit for TPL settlements and awards in accordance with Federal laws and regulations, regardless of its own State laws.

DHS's Comments

The DHS did not concur with our position on the issue of the 50 percent rule or the compromise rule. Specifically, DHS did not agree with our application or interpretation of the Act, Federal regulations, or the California State Plan. It maintained that following its own State laws would result in greater recoveries.

On the issue of how a settlement or award should be distributed, DHS stated that Federal law was silent on how a recipient's settlement or award of a tort claim should be treated. Specifically, DHS claimed that Federal law only addressed the distribution of funds after the State collected the money from the recipient or third party.

The DHS claimed that the OIG misunderstood the intent and the effect of the 50 percent rule. It contended that its 50 percent rule provided an incentive for recipients to pursue liable third parties.

Additionally, DHS maintained that the cost to both the State and Federal Governments would be prohibitive if DHS were to attempt to investigate and prosecute each recipient's personal injury claim on its own. To support its position, it cited a 1991 court case, Bales v. Iowa, as an example where the State had to pursue the liable third party on its own because it failed to negotiate with the recipient and third parties during the settlement process.

Regarding the issue on recipients' assignment of rights, DHS maintained that those rights pertained only to health care benefits and did not include claims for personal injury where a third party may not be liable until such liability had been established.

Finally, the State insisted that it must have the authority to compromise with third parties and recipients in order to avoid litigation. In this way, it believed that the number of settlements could be maximized.

OIG's Comments

We believe that our interpretation of the Federal criteria that States are precluded from effectively providing settlement monies to recipients before properly crediting the Federal Government with its share is correct.

Regarding DHS's contention that the law only dealt with recoveries collected by the State and not those collected by recipients, the recipients essentially collected the payments on behalf of the State since recipients assigned their rights of recovery as a condition of eligibility. Carrying DHS's interpretation to the extreme could mean that the State would not be entitled to any of the recipients' recoveries. We believe that such an interpretation was certainly not intended by the Congress.

The DHS stated that the intent of the 50 percent rule was to provide recipients with an incentive to pursue recovery. Such a rule, however, is not warranted because existing incentives already exist. First, attorneys usually pursue tort claims on a contingency basis, and, thus, recipients incur no attorney fees if unsuccessful. Second, the State and Federal Governments share in any legal fees and costs if recovery is successful. Third, in our opinion, recipients will continue to seek legal action for recovery because of the potential to recover any amount. We believe that recipients will simply seek and receive greater amounts from third parties so that the recipients obtain funds for their own use.

In those cases involving liability insurance where the probability is likely that only policy limits are available and that amount does not exceed the State's net lien (i.e., the recipient will receive nothing), then under Federal law (section 1902(a)(25)(B) of the Act) and regulations (42 CFR 433.139(b)(3)) the State itself is obligated to pursue action against the third party and recipients are obligated to cooperate in that pursuit as a condition of their eligibility. The only exception granted to the State is when its costs are expected to exceed the recovery.

The DHS did not provide any data to support its view that under our interpretation recipients would be less likely to seek recoveries from third parties. The DHS's contention that an additional incentive is needed does not overcome the statutory requirement that the Federal Government receive its full share first.

The DHS also contended that costs would be prohibitive if it were to pursue third parties on its own and cited the Bales v. Iowa case. In that case, the State of Iowa sought during settlement negotiations to recover the total amount it had spent for medical care for a recipient. The third parties were seeking to pay a lesser amount. Ultimately, the third parties and the recipient agreed to a settlement that specifically excluded any claim for medical expenses. The State of Iowa then tried to recover its Medicaid expenses from the settlement proceeds. The district court and Iowa Supreme Court ruled that there was no recovery of medical care funds for which the State was entitled. The State, therefore, was forced to either pursue its claim against the third parties or forego it.

The facts in that case, however, do not illustrate the problems involved in the 50 percent rule. All of the sample errors in our review involved recipients who had already reached agreements with the third parties on amounts that involved medical expenses. Even if the State of Iowa had its own version of the 50 percent rule, the case decision would have been no different. That is, the State of Iowa simply acquired all rights, securities, and remedies of the recipient and could not acquire any claim, security, or remedy that the recipient did not have.

The DHS also claimed that recipients' assignments of rights pertained only to health care "benefits" provided by others, such as health care plans, casualty insurance, or uninsured motorist coverage and did not apply to "unperfected and unliquidated" tort claims. However, the statute (section 1912(a) of the Act) does not limit the source of third party liability payments. It specifically includes "...medical support payments and other payments for medical care owed to recipients...." (emphasis added) In our sample, all the cases involved claims that had either reached a negotiated settlement between the parties or an award was made by a court--none involved "unperfected" or "unliquidated" claims. In addition, almost all of the cases probably involved insurance since payments are generally not made by individual parties without benefit of insurance coverage.

Regarding the compromise issue, DHS did not provide any evidence to support its claim that having compromise authority with recipients after the amounts of third party payments had been agreed upon would maximize the number of such settlements. In fact, all of the 78 cases in our sample for which we questioned the Federal share of the State's compromises involved compromises

with recipients after the recipients had already reached settlements or received awards. Allowing DHS to provide additional settlement monies to recipients after the amount of recovery from third parties had been established and agreed upon is not equitable to the Federal Government which has paid its share of the medical expenses.

Final determination as to actions taken on all matters reported will be made by the HHS official below. We request that you respond within 30 days to the HHS official named below, presenting any additional comments or information that you believe may have a bearing on his final decision. To facilitate identification, please refer to common identification number A-09-92-00095 in all correspondence relating to this report.

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In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

Sincerely yours,



HERBERT WITT
Regional Inspector General
for Audit Services

Direct Reply To HHS Action Official:

Gerald M. Moskowitz
Regional Administrator
Health Care Financing Administration
75 Hawthorne Street
San Francisco, California 94105

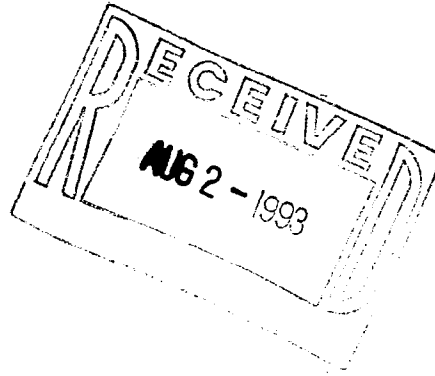
APPENDIX

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

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JUL 29 1993

Mr. Herbert Witt
Regional Inspector General
for Audit Services
Office of Inspector General, Region IX
Office of Audit Services
50 United Nations Plaza
San Francisco, CA 94102

DRAFT AUDIT REPORT A-09-92-00095 OF MAY 26, 1993
DEPARTMENT OF HEALTH SERVICES NO. 92-12

Dear Mr. Witt:

This responds to your letters of May 26, and July 7, 1993, concerning the referenced draft audit report relating to Department of Health Services (DHS) recovery of Medicaid third party liability (TPL) payments for the period of July 1, 1988 through June 30, 1992. The draft audit report has been reviewed and our comments are set forth below.

STATEMENT OF CONCURRENCE OR NONCONCURRENCE

We do not concur with your application of and interpretation of the applicable provisions of the Social Security Act, federal regulations, directives, and the California State Plan.

REASONS FOR NONCONCURRENCE

BACKGROUND

The draft audit examines third party personal injury tort liability (tort liability) recovery by DHS, which is only a small part of overall TPL recovery. Recovery from health plans, worker's compensation, private casualty insurance, etc., is not included in the audit.

In 1976, California enacted a comprehensive scheme of tort liability recovery as Welfare and Institutions Code, division 9, part 3, article 3.5 (§§ 14124.70-14124.90), which has enabled California to recover more Medicaid (Medi-Cal) funds for the state and federal governments than any other state. The program was highlighted by the Health Care Financing Administration (HCFA) and Department of Health and Human Services (DHHS) as a model for other

Mr. Herbert Witt
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states to follow. Several years after the program was initiated and copied by other states, DHHS changed its position on the legality of the California program. This audit is the result of that change in position.

Federal Medicaid law provides authority for state Medicaid programs to collect from third parties who are liable for payment of health care services given to Medicaid beneficiaries. Each beneficiary is required as a condition of eligibility to assign legal entitlements for health care to the state. A cause of action in tort for a personal injury is not a legal entitlement until the case is litigated or settled, liability is established, and a party awarded damages. The award may or may not segregate one item of recovery from the other, but may simply award a lump sum. California has enacted legislation that has created an incentive for beneficiaries to sue tortfeasors for damages in cases in which the Medi-Cal program has provided health benefits. This legislation encourages beneficiaries to perfect mere expectancy interests into legal entitlements that are recoverable. Their counsel are required to report these legal entitlements to the state.

The draft audit frustrates the effectiveness of this statute by seeking to recover amounts recovered by the beneficiary but not by the state. This position requires the state to pay DHHS half of a beneficiary's medical expenses notwithstanding the amount collected by the state. In some cases the State would be required to give more to DHHS than it collects. Following DHHS's interpretation makes the statute not cost effective. This audit subject is not unique to California. Arkansas had a 50% statute and repealed it after being found out of compliance by DHHS. The lesson learned by the states is that when they have a recovery statute that is not mandated by federal law, and DHHS's interpretation of that law causes them to pay more in recoveries than they receive, their only recourse is to repeal the state statute. Thus, the DHHS interpretation leads to a reduction in recoveries, not an increase.

The draft audit singles out two sections of the Welfare and Institutions Code, section 14124.78, the "50 percent rule" and section 14124.71(b), "hardship compromise" and alleges that they are contrary to federal law. These sections address the State's method of perfecting an inchoate claim into one that is both assignable and recoverable.

Federal law is silent in establishing how a beneficiary's award or settlement of a tort claim is to be treated. Federal law addresses only the situation after the state has collected the money from the beneficiary or from the third party on behalf of the beneficiary.

Mr. Herbert Witt
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THE "50 PERCENT RULE"

California Welfare and Institutions Code section 14124.78 provides that the Director's claim will not exceed one-half of the beneficiary's recovery after specified deductions. The intent and the effect of the section appears to have been misunderstood by the auditor.

This section gives a beneficiary an incentive to pursue a third party who may be legally liable to respond in damages for his or her injury. Damages may, and frequently do, include medical expenses caused by a tortfeasor.

The law was enacted after extensive negotiations with the California Trial Lawyers Association to reach a percentage which would offer the incentive needed to make the legislation work. The legislation takes an expectancy interest or inchoate claim, and permits perfecting it to the point where the State has an enforceable cause of action. This law is, in effect, a statutory compromise methodology for recovery of claims which a state might not have access to without extensive legal and administrative costs. It encourages settlement and compromise, both of which the state has inherent authority to exercise whenever necessary to recover against a third party tortfeasor.

The cost to DHS (and to the federal government) would be prohibitive if DHS were to attempt to investigate and prosecute each beneficiary's personal injury claim individually. There would be recovery for the State only if it were able to establish liability. In many cases there would be no liability and thus no recovery. By giving beneficiaries the incentive to employ private attorneys to prosecute personal injury claims, the recovery of state and federal money is maximized and the costs are minimized.

In a 1991 Iowa case (Bales v. Iowa (1991) 478 N.W.2d 398, 398) the State tried to recover from a tort settlement received by a beneficiary, for payments the State had paid for medical assistance benefits caused by the tort. The settlement excluded an award for medical expenses. Because Iowa refused to compromise its claim, the settlement proceeded on aspects of damages excluding medical expenses; and Iowa was forced to pursue its claim on its own or forgo the claim entirely. Experience has demonstrated that looking for a tortfeasor without an incentive statute is not cost effective. A federal regulation recognizes this frustration and permits states to forego attempted recovery of such claims (42 C.F.R. § 433.139).

Federal law does not expressly provide instructions for the distribution, between federal and state governments, of damages for medical expenses collected by the beneficiary. For this

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instruction, we must rely on general distribution statutes which deal with money after it is collected by the state. The draft audit disregards the general rule, and attempts to distribute the money before it is collected.

ASSIGNMENT OF CLAIMS

Federal law, regulations, and the approved California State Plan provide that an applicant for Medi-Cal (Medicaid) benefits must assign any claim against a third party who may be liable to pay health care benefits to the State. The law does not address unperfected and unliquidated tort claims.

Assignment is effective when the beneficiary has his or her own health plan, casualty insurance policy, or uninsured motorist coverage, but assignment is not effective to assign a claim for personal injury where a third party may not be liable until such liability is established.

It appears that the Office of Inspector General (OIG) has misinterpreted the intent of federal law to include the assignment of a mere expectation, an inchoate claim, for negligent personal injury, which is not assignable.

For numerous reasons, claims for personal injury, caused by the negligence of a third party, do not fit into the federal statutory and regulatory scheme. This fact should be recognized by the OIG and by HCFA; and the State should be allowed to continue pursuit of reimbursement from tort damages in a cost effective way -- a way that has been proven to maximize recovery of both state and federal money.

UNDUE HARDSHIP WAIVERS (COMPROMISES)

Welfare and Institutions Code section 14124.71(b) gives the Director additional authority to settle litigation by compromise or waiver of reimbursement for several reasons including cost effectiveness and undue hardship.

Without the authority to compromise, every case would have to be litigated to a conclusion. Because these are "third party" cases, there must be authority to compromise with the alleged tortfeasor and with the beneficiary. The supposition that settlement maximizes recoveries should not be open to question. It is common knowledge that the bulk of tort claims (over 80% of medical malpractice claims) are settled by private litigants without the expense of trial simply because compromise and settlement are cost effective.

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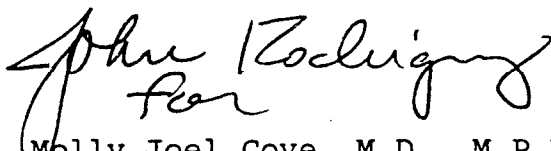
CONCLUSION

We do not believe the correct interpretation of federal law and regulations is that DHS is required to recover up to the entire amount of the medical award or settlement. DHS does seek recoveries as required by federal law and the State Plan. We enhance these recoveries by a state law which specifically addresses personal injury tort recovery. California continues to be the leader in tort recoveries. DHHS's position would seriously erode the State's effectiveness in this area.

It is the position of DHS that the OIG has misinterpreted federal law. If the state were to follow this interpretation, it would substantially reduce the State's incentive to pursue tortfeasor claims. Both the state and federal government become losers. We strongly recommend that DHHS review OIG's interpretation of the policy.

If you have any questions regarding this matter, please contact John Rodriguez at (916) 654-0391.

Sincerely,

A handwritten signature in dark ink, appearing to read "Molly Joel Coye".

Molly Joel Coye, M.D., M.P.H.
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